



Review of Systems Worksheet

Patient Name: _____ Date: _____

Please check all that apply to you:

1. General

- | | |
|--|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Unexplained hair loss (alopecia) |
| <input type="checkbox"/> Fever or chills | |

2. Eyes

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Vision problems (blurred vision, loss of vision) | |

3. Ears/Nose/Mouth/Throat

- | | |
|--|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Swollen glands in neck |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sore throat/pain when swallowing |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Mouth sores |

4. Cardiovascular

- | | |
|--|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Leg pain in calf or thigh of leg |
| <input type="checkbox"/> Chest pain (sharp, crushing, or heaviness) | <input type="checkbox"/> Aching/Burning in legs |
| <input type="checkbox"/> Heart racing (palpitations) | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Sudden shortness of breath at night or lying down | <input type="checkbox"/> Swelling of legs (Edema) |

5. Respiratory

- | | |
|--|--|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cough/coughing up blood |

6. Gastrointestinal

- | | |
|---|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Increased appetite |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | |

7. Genitourinary

Men and Women:

- | | |
|---|---|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Sores (vagina, penis, rectum) |
| <input type="checkbox"/> Pain when passing water (urination) | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Passing water more than usual (day and/or night) | <input type="checkbox"/> Bladder Infection/other infections |
| <input type="checkbox"/> Pain during sex | <input type="checkbox"/> Changes in sex drive (libido) |

Women:

- | | |
|---|---|
| <input type="checkbox"/> Irregular periods (menstruation) | <input type="checkbox"/> Painful periods (menstruation) |
| <input type="checkbox"/> Increased or too little bleeding during periods (menstruation) | |
| <input type="checkbox"/> Three or more yeast infections in a year | <input type="checkbox"/> Discharge from vagina |

Men:

- | | |
|--|--|
| <input type="checkbox"/> Discharge from penis (drip) | <input type="checkbox"/> Swelling in balls (scrotum) |
|--|--|

8. Musculoskeletal

- | | |
|--|--|
| <input type="checkbox"/> No problems | <input type="checkbox"/> Limited motion of arms or legs |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Swelling/Redness If so, where _____ |
| <input type="checkbox"/> Numbness, tingling, or weakness in arms or legs | <input type="checkbox"/> Pain in calf or thigh |

9. Neurological

- ☐ No problems
- ☐ New headaches
- ☐ Headaches with vision changes

- ☐ Arm/Leg weakness
- ☐ Repeated bad headaches
- ☐ Problems with memory or speech

10. Psychiatric

- ☐ No problems
- ☐ Suicidal or homicidal thoughts

- ☐ Seeing or hearing things (Hallucinations)
- ☐ Mood swings

11. Endocrine

- ☐ No problems
- ☐ Thirsty all the time
- ☐ Increased facial hair (females only)

- ☐ Weight gain/loss
- ☐ Can not stand temperature changes (heat/cold)

12. Lymph

- ☐ No problems

- ☐ Swollen glands (armpits or groin)

13. Skin

- ☐ No problems
- ☐ Changes in skin

- ☐ Rash (palm of hands, sole of feet)
- ☐ Sores or rash on skin

14. Allergies

- ☐ No problems
- ☐ Hives/skin rashes

- ☐ Allergic reaction to drugs
- ☐ Allergic reaction to foods

15. OtherPlease write in:

[illegible]

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
Review of Systems Worksheet- DHEC 0786 (12/2006)
(Instructions for Completing)

Purpose:

To provide a uniform system for collecting client's interval history including review of systems. Information collected will be used in the delivery of health services.

Explanation and Definition:

The form is to be used for patients receiving public health services. The extent of the information collected will depend on the patient and the reason for services. All items are to be completed in pen. Refer to program guidelines to determine when this form is to be completed.

General Instructions for Use:

The Review of Systems Worksheet is to be completed by the patient or caregiver. If the patient or caregiver is not able to complete the form, the health professional will complete it. Refer to program guidelines to determine when this form is to be completed.

The patient will complete the appropriate sections.

Upon completion of the form by the patient or caregiver, the health professional reviews the worksheet. Pertinent questions are asked to clarify the information provided. The health professional documents pertinent information on the Clinical Encounter Form (DHEC 3212).

Office Mechanics and Filing:

Once the health care provider has reviewed the form, the original should be shredded. **The form is not to be filed in the Comprehensive Health Record. It is only utilized for data collection purposes.**